MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11457

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 26 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 1 month, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 322 E. St., S. W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME MARGARET C. ALLEN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: Edward Allen

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 18, 1879

8. AGE: Years	Months	Days	If less than one day
68 68	11	3	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: - -

FATHER 12. Name: Daniel Harris

13. Birthplace: Oxen Hill, Maryland

MOTHER 14. Maiden name: Martha Holton

15. Birthplace: Oxen Hill, Maryland

16. Informant: Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof Dec. 22, 1947 (month) (day) (year)

Cemetery or crematory

Location: to Washington, D.C.

18. Funeral director: Mortuary

Address: 600 - 22 St., N.W.

19. Dec. 22, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 21st 1947 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 24th 1947 to Dec 21st 1947 and that I last saw h. alive on Dec 21st 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	10 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Md. Date signed 12/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

153 11458

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Pro Geo Co
City or town: Hyattsville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pro Geo Co.
City or town: Hyattsville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4409 Oliver st
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Flora Rita Anderson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Philip Anderson
6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): Aug 7, 1921

8. AGE: Years: 26 Months: Days: If less than one day: hrs. min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual occupation: At home

11. Industry or business:

FATHER
12. Name: Vincent Marcellino
13. Birthplace: Italy

MOTHER
14. Maiden name: Salvatrice Scaletta
15. Birthplace: Italy

16. Informant: Philip Anderson
Address: Hyattsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 9 1947 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln
Location: Washington D.C.

18. Funeral director: E. Blaschia Sons
Address: Hyattsville Md.

19. Dec 9 1947 (Date rec'd by registrar) James Sevar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 6 1947, at 9:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-11 1947, to 12-6 1947 and that I last saw h[illegible] alive on 12-1-47 1947

Immediate cause of death	DURATION
Scleroderma	3 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John P. Clum M.D.
M. D. or other
Address: Hyattsville Md Date signed: 12-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

11459

CERTIFICATE OF DEATH

Reg. Diat. No. 242

1. PLACE OF DEATH:

County Prince George's

City or town Seat Pleasant

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 years

Hospital, institution, or street address where death occurred:

6723 Roosevelt Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Seat Pleasant

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6723 Roosevelt Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Louise Augustine

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife Fabian A. Augustine

6.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) March 27, 1876

8. AGE:	Years	Months	Days	If less than one day
	71			hrs. min.

9. Birthplace Germany (Town, County, and State)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name John William Jr. Bohert

13. Birthplace Germany

MOTHER 14. Maiden name Louise Uhlmann

15. Birthplace Germany

16. Informant Louise Parker

Address 6723 - Roosevelt Ave Seat Pleasant

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 9 1947 (month) (day) (year)

Cemetery or crematory Cedar Hill Cem

Location Prince Georges Co

18. Funeral director G. W. M. Lees Sons

Address 360 - 4th St N.E. Washington

19. Dec. 8 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1947 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy Medical Examiner M. D. or other

Address Forestville Md Date signed 12-7-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11460

Reg. Dist. No. 239

1. PLACE OF DEATH:

County: Prince George

City or town: Oakcrest

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County: Madison

City or town: Brightwood

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Martha Lurenia Banks

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widowed

6.(b) Name of husband or wife: John William Banks

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 26, 1867

8. AGE: Years: 80 Months: 11 Days: If less than one day: hrs. min.

9. Birthplace: Madison, Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: William Clare
13. Birthplace: Madison, Virginia

MOTHER
14. Maiden name: Jane Burke
15. Birthplace: Madison, Virginia

16. Informant: Dolores Tucker

Address: 1763 Q St N.W. Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 29, 1947 (month) (day) (year)

Cemetery or crematory: Baptist Church Cem.

Location: Madison, Virginia

18. Funeral director: De Witt Davidson

Address: Laurel, Maryland.

19. Dec. 27 1947 (Date rec'd by registrar) M. Brashears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26 19 47, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 1st 1947, to Dec. 26 1947

and that I last saw h[illegible] alive on Dec. 26 1947

Immediate cause of death	DURATION
Hypertensive Cardio-Vascular Disease	1 yr.
Due to: Arteri-sclerosis-	5 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

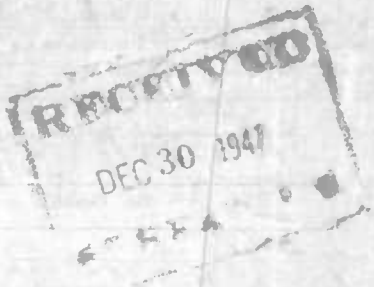
23. SIGNATURE: Frank S. Shipley, M.D. (M. D. or other)

Address: Savage, Md. Date signed: 12/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160c

11461

CERTIFICATE OF DEATH

Reg. Dist. No. 247

1. PLACE OF DEATH:

County Prince George's

City or town Capital Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, Institution, or street address where death occurred:

6218 Kingston Ave

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Capital Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6218 - Kingston Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Baby Barefoot

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1947

8. AGE: Years | Months | Days | If less than one day hrs. few min.

9. Birthplace Capital Heights, Md (Town, county, and state)

10. Usual occupation none

11. Industry or business none

FATHER 12. Name Carl Desmond

FATHER 13. Birthplace Unknown

MOTHER 14. Maiden name Helen Barefoot

MOTHER 15. Birthplace Delaware

16. Informant Helen Barefoot

Address Capital Heights Md

17. Burial Date thereof Dec 13, 1947.

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Evergreen Cemetery

Location Bladensburg Md

18. Funeral director F Gaschler Sons

Address Hyattsville Md.

19. Dec 13 1947 Amanda Wooding Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1947, at 10 00 A.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Asphyxia	
Due to Suffocation	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner M. D. or other

Address Hyattsville Md Date signed 12-11-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of date of death shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11462

936

FILM No. G 114 JAN 28 1948 **CERTIFICATE OF DEATH**

Reg. Diat. No. 231

1. PLACE OF DEATH:
County Prince George
City or town Cheverly, 1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 29 days 9 hours
Hospital, institution, or street address where death occurred:
Prince George's General Hospital
How long in hospital or institution? 29 days 9 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George
City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3111 Upshur St.
(If rurol, give LOCATION)
2.(a) If veteran, name war W. W. I.

3. (a) FULL NAME Frank A. Barry

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married.

6.(b) Name of husband or wife Mrs. Helen Barry
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 10, 1894

8. AGE: Years	Months	Days	If less than one day
53	4	1	..... hrs. ..... min.

9. Birthplace New York
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business National Bureau of Standards

FATHER 12. Name Barry, Mr. John J.
13. Birthplace Ireland

MOTHER 14. Maiden name Elizabeth O'Keefe
15. Birthplace Ireland

16. Informant Mr. E. J. Murphy, Jr.
Address 2700 Conn. Ave Northwest

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 14 47 (month) (day) (year)
Cemetery or crematory Ark. Natl. Cem.
Location Ark. Va.

18. Funeral director W. W. Chambers Co
Address 1400 Chapin St N.W.

19. 12/11 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1947 at 5:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-1 1947, to 12-11 1947 and that I last saw h. alive on 12-11 1947

Immediate cause of death	DURATION
(a) Coronary Occlusion with Pulmonary Congestion	10 days
Due to (b) Arteriosclerotic Heart Disease	2 yrs ?
Due to (c)	
Other conditions 1. Pituitectomy & Goiter	10 yrs ?
2. Chronic Abscess of Breast	24 hrs.

(Include pregnency within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE W. B. Magruder M. D.
M. D. or other
Address Mt. Rainier Md Date signed 12-11-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

B0 11463 232

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Prince Georges
City or town Naylor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Naylor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Russell John Beall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years 29 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Upper Marlboro, Md
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Farm

FATHER
12. Name Benjamin F. Beall
13. Birthplace Upper Marlboro, Md

MOTHER
14. Maiden name Florence E. Parker
15. Birthplace Charles Co. Md

16. Informant William R. Beall
Address Upper Marlboro, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-10-47 (month) (day) (year)
Cemetery or crematory Pr. Geo. Co. Alms House
Location Pitchy, Md

18. Funeral director Pitchie Bros.
Address Upper Marlboro, Md.

19. Dec 9 1947 Rand Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1947, at 3:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death ..... DURATION
Universal Cancer
burns of the body
Due to .....
Due to .....
Other conditions .....
(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of 12-7-47
Where did injury occur? Naylor (City or town) P.G. (County) Md (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Burns Injured at work? No

23. SIGNATURE James J. [illegible] M. D. or other
Deputy medical examiner
Address Forestville Md Date signed 12-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1626 11464

CERTIFICATE OF DEATH

Reg. Diat. No. 045

1. PLACE OF DEATH:
County: Prince George's
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4205 30th St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Annie Blair

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	N.	Widowed

6.(b) Name of husband or wife: James E. Blair. Deceased. 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): - 1866

8. AGE:

Years	Months	Days	If less than one day
81	11	2	..... hrs. ..... min.

9. Birthplace: Richmond, Va.
(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business:

FATHER
12. Name: Richard Duke
13. Birthplace: Va. Albemarle

MOTHER
14. Maiden name: Virginia Baldwin.
15. Birthplace: Va.

16. Informant: Charlotte Blair Powell.
Address: 4205 30th St Mt Rainier Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 9 1947 (month) (day) (year)
Cemetery or crematory: Oakwood
Location: Richmond, Va.

18. Funeral director: L. H. Hines Co.
Address: 2901 14th St. N.W. Wash DC

19. Dec. 8 19 47 (Date rec'd by registrar) Mrs. Jas. Devere Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-8 19 47 at 9:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-24 19 46, to 12-8 19 47
and that I last saw h[illegible] alive on 12-8 19 47

	DURATION
Immediate cause of death: Senility	2 yrs+
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M.D.
M. D. or other
Address: Mt. Rainier Md. Date signed: 12-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1310 11465

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Cornish Hills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

517-72nd Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Cornish Hills

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 517-72nd Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Amos Bonawitz

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Caroline K. Bonawitz

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb 9, 1861

8. AGE: Years: 86 Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Illinois (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Farmer

FATHER 12. Name: Unknown

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Unknown

16. Informant: Grace Hoppe

Address: 517-72nd St, Cornish Hills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 21, 1947 (month) (day) (year)

Cemetery or crematory: Fairbury, Nebraska

Location:

18. Funeral director: W. W. Chambers Co.

Address: 517-11-St. Wash., D.C.

19. Dec. 21 1947 (Date rec'd by registrar) Carrie F. Campfield Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 19 1947, at 5 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary thrombosis	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy medical Examiner M.D. or other

Address: Greenbelt Md. Date signed: 12-19-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11466

92e

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:
County: Prince George
City or town: Laurel, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all of life
Hospital, institution, or street address where death occurred:
Brooklyn Bridge Rd.; Laurel, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Brooklyn Bridge Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Wilhemina Katherina Bayle

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	

6.(b) Name of husband or wife: Jonah Bayle
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 26, 1878

8. AGE: Years	Months	Days	If less than one day
69	8	24	hrs. min.

9. Birthplace: Guilford, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Adolph Schmidt
13. Birthplace: Germany
MOTHER 14. Maiden name: Louise Wunderwirth
15. Birthplace: Germany
16. Informant: Henry D. Bayle
Address: Edgewater P. O., Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 28 1947 (month) (day) (year)
Cemetery or crematory: Ivy Hill
Location: Laurel Md
18. Funeral director: Ridgley & Selby
Address: 401 Wash. Ave. Laurel, Md.
19. 12-27 1947 (Date rec'd by registrar) Cora E. Waldron Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/24 1947 at 4:4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 8 1947 to Dec 24 1947 and that I last saw h[er] alive on Dec Dec 23 1947

Immediate cause of death	DURATION
Myocarditis	7
Senilecachexia	1
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: injured at work?

23. SIGNATURE: M D or other
Address: Laurel Date signed 12/27/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11467

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Cheverly Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Prince George Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
Street No. 10 M Laurel Bowie Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ~~Baby Girl~~ Mary Kathleen Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W	Single

6.(b) Name of husband or wife: Brown, Mrs Mary
6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): December 9, 1947

8. AGE: Years | Months | Days | If less than one day: 0 hrs. 22 min.

9. Birthplace: Prince George's Hosp., Cheverly, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Austin S. Brown
13. Birthplace: Washington, D.C.

MOTHER
14. Maiden name: Mary Fletcher
15. Birthplace: Washington, D.C.

16. Informant: Mrs. Mary Brown
Address: 10 M Laurel Bowie Rd. Greenbelt

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/11/47 (month) (day) (year)
Cemetery or crematory: Evergreen Cemetery
Location: Bladensburg, Md.

18. Funeral director: J. Lasche's Sons
Address: Hyattsville, Md.

19. 12/11 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-9 1947, at A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h ..... alive on ..... 19.....

Immediate cause of death	DURATION
Atalectasis	
Due to: Prematurity	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: Francis Loureu M.D.
M. D. or other
Address: 1746 - K St NW Date signed: 12/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11468

170c

Reg. Diat. No. 231

1. PLACE OF DEATH:

County: Prince George's

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Dead on arrival

Hospital, institution, or street address where death occurred: Prince Georges General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: District of Columbia

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 226 - L Street S.E.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Margaret Buchanan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 15, 1922

8. AGE: Years 25 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: At home

11. Industry or business

FATHER — 12. Name: Albert Buchanan

13. Birthplace: Washington, D.C.

MOTHER — 14. Maiden name: Eleanor Page

15. Birthplace: Hartford, Conn.

16. Informant: Albert Buchanan

Address: 318-M St. N.E., Washington, D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Dec. 21, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Hope

Location: Washington D.C.

18. Funeral director: Barnes & Matthews

Address: 614-4th St. S.W. D.C.

19. Dec 21 1947 (Date rec'd by registrar) James Seney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 21 1947 at 3:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to: Crushed skull	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of 12-21-47

Where did injury occur? Beaver Heights P.G. Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where)? Addison Chapel Road

Means of injury? Passenger in car hit by train

Injured while working?

23. SIGNATURE: James E. Boyd M.D. or other

Deputy medical Examiner

Address: Hyattsville Md Date signed: 12-21-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11469

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 314 245

1. PLACE OF DEATH:
County: Prince George
City or town: Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington, D.C
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5815-13th. St. N.W
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: FANNIE A. BURLINGAME

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widow

6.(b) Name of husband or wife: Harry T Burlingame
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unobtainable

8. AGE:	Years	Months	Days	If less than one day
About	84			hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Unobtainable
13. Birthplace: "

MOTHER
14. Maiden name:
15. Birthplace: "

16. Informant: Gertrude S. Story
Address: 6120-Baltimore St Riverdale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 8, 1947 (month) (day) (year)
Cemetery or crematory: Arlington Natl. Cem
Location: Arlington Va

18. Funeral director: The S. H. Hines Co
Address: 2901-14th. ST. N.W

19. Dec 5 1947 (Date rec'd by registrar) Josephine M Schaffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 5 1947, at 4" P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 20 1947, to Dec 5 1947
and that I last saw h[illegible] alive on Dec 4 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	
Hypostatic pneumonia	1 week
Due to Generalized arthritis - sclerosis	15 yrs.
Due to	
Other conditions none	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dwight H Duffey M.D.
M. D. or other
Address: 4600 Argyle Terr. N.W. Date signed: 12/5/47.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47c

11470

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:
County Pro Geo Co
City or town Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Pro Geo Co
City or town Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6004 - 44 ave
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Frederick Collins Burrhus

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Noma Burrhus
6.(c) If alive, give age 72 years
7. Birth date of deceased (mo., day, yr.) Dec 25, 1881

8. AGE: Years 65 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual occupation Photo engraver
11. Industry or business Southern Engraving Co Balto Md.

FATHER
12. Name Frederick C. Burrhus
13. Birthplace N. Y.

MOTHER
14. Maiden name Flora Lynch
15. Birthplace Ohio

16. Informant Mrs Noma Burrhus
Address Hyattsville Md

17. Burial Date thereof Dec 24, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Ft Lincoln
Location Washington D.C.

18. Funeral director J Gracie's sons
Address Hyattsville Md.

19. Dec. 24 1947 Mrs. Jas. Severe
(Date rec'd by registrar) (Deputy Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21. 1947, at 10:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~Dec 4, 1947~~ Nov 28, 1947 to Dec 21 1947
and that I last saw h alive on December 19 1947

Immediate cause of death	DURATION
Primary Carcinoma of Bronchus	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L W Malone MD
M. D. or other
Address Riverdale Md Date signed 12-22-47

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11471

Reg. Dist. No. 232

1. PLACE OF DEATH:
County: Prince George
City or town: Leeland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Leeland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Catherine Emma Butler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	colored	married

6.(b) Name of husband or wife: Joseph O. Butler
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 15-1891.

8. AGE: Years: 56 Months: 1 Days: 12 If less than one day: hrs. min.

9. Birthplace: Mt. Calvert, Pr. Geo. Co., Md.
(Town, county, and state)

10. Usual occupation: At home

11. Industry or business:

FATHER
12. Name: Thomas Proctor
13. Birthplace: Charles Co., Md.

MOTHER
14. Maiden name: Sarah E. Butler
15. Birthplace: Pr. Geo. Co., Md.

16. Informant: Joseph O. Butler
Address: Upper Marlboro, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 12-30-47 (month) (day) (year)
Cemetery or crematory: Mt. Carmel
Location: Upper Marlboro, Md.

18. Funeral director: Ritchie Bros.
Address: Upper Marlboro, Md.

19. Dec 29 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 27 Dec 1947 at 5:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 Dec 1947 to 27 Dec 1947 and that I last saw h.. alive on 27 Dec 1947

Immediate cause of death	DURATION
Cerebral vascular accident	1 hr
Due to: Hypertensive C.V. disease	Unk
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R B Lasseter M D
M. D. or other
Address: Upper Marlboro, Md. Date signed 27 Dec 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 11472

Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George's

City or town: Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, Institution, or street address where death occurred:

Prince George's General

How long in hospital or institution? 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: University Park, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4301 Woodbury

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Arthur Carr

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Jennie C. Carr

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 31, 1885

8. AGE: Years	Months	Days	If less than one day
62	4	25	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Real Estate

11. Industry or business:

FATHER — 12. Name: Arthur Carr

13. Birthplace: Friendship Md

MOTHER — 14. Maiden name: May Ellen Hardesty

15. Birthplace: Md.

16. Informant: Hospital records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 27. 1947 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln

Location: Washington D.C.

18. Funeral director: J Gasche Sons

Address: Hyattsville Md.

19. 12/26 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 25 1947 at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 23 1946 to Dec. 1 1947

and that I last saw h... alive on Dec 25 1947

Immediate cause of death	DURATION
Hypertensive Cardio-Vascular Disease	8 yrs ?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W B Magruder M.D. (M. D. or other)

Address: Mt. Rainier Md. Date signed 12-2-47

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. Use correct age if exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47c

11473

CERTIFICATE OF DEATH

Reg. Dist. No. 345

1. PLACE OF DEATH:
County: Prs Geo Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 48 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prs Geo Co
City or town: Hyatteville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4506 Buchanan st
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ellen J. Coates

3.(b) Social Security Number 216-01-3624

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or ~~wife~~: Hans Coates

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): 12 March 1882

8. AGE: Years: 65 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Landover, Pro. Geo; Md. (Town, county, and state)

10. Usual occupation: Sales Lady

11. Industry or business: Retired

FATHER — 12. Name: Jashua Q. Shipley
13. Birthplace: Maryland

MOTHER — 14. Maiden name: Lavenia Beal
15. Birthplace: Maryland

16. Informant: Hans Coates
Address: Hyattsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 15, 1947 (month) (day) (year)
Cemetery or ~~crematory~~: Fort Lincoln
Location: Washington D. C.

18. Funeral director: F. Gaeke Long
Address: Hyattsville Md.

19. Dec. 14 1947 (Date rec'd by registrar) James Devere Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-13 1947, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-4 1947 to 12-13 1947 and that I last saw h alive on 12-13 1947

Immediate cause of death	DURATION
Bronchogenic Carcinoma Right Lung	
c Cerebral Metastases	4 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M.D. (M. D. or other)
Address: Mt. Rainier Md Date signed 12-14-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11474

182

Reg. Diat. No. 242

1. PLACE OF DEATH:

County: Prince George's

City or town: Dupont Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Dupont Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME 326

John Thomas Coates

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 12, 1947

8. AGE: Years | Months: 2 | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Upper Marlboro, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: John Thomas Coates

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Lillian E. Thomas

15. Birthplace: Washington, D.C.

16. Informant: Lillian E. Coates

Address: Dupont Heights, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 28-47 (month) (day) (year)

Cemetery or crematory: R. Stallings Cemetery

Location: Mellwood Pr. Geo's Co. Md

18. Funeral director: Bryant McNeill & Lemar Chestnut

Address: Mellwood Pr. Geo's Co. Md.

19. Jan. 2 1948 Edna F. Collins Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 28 1947 at 10:00A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Asphyxia	
Due to: Overlaying of mother	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date 12/28/47

Where did injury occur? Dupont Heights P. G. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Mother lay on child during sleep Injured at work?

Deputy Med. Examiner

23. SIGNATURE: James S. Boyd M.D. or other

Address: Forestville, Md. Date signed 12/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct and complete as is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11475

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mos., 13 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 8 mos., 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 709 - 8th St., N. E. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: WILLIAM E. CONNELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Zudie Connell

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): June 16, 1879

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68	5	17		

9. Birthplace: Maryville, Ohio (Town, county, and state)

10. Usual occupation: Government Guard

11. Industry or business: - - -

FATHER — 12. Name: John G. Connell

FATHER — 13. Birthplace: ? Pennsylvania

MOTHER — 14. Maiden name: Mary E. Blackburn

MOTHER — 15. Birthplace: Zanesville, Ohio

16. Informant: Decreased

17. Address: Removal + Burial (Burial, cremation, or removal. Which?) Date thereof 12/3/47 (month) (day) (year)

Cemetery or crematory: to Washington D.C. + Burial at Cedar Hill, Anne Arundel Co. Md.

Location:

18. Funeral director: Lee Funeral Stand

Address: 300 - 4th St. N.E. Washington D.C.

19. Dec 3 1947 (Date rec'd by registrar) Rowland S. Phelps, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 3, 1947 at 12:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 19, 1947 to Dec. 3, 1947 and that I last saw h... living on Dec 2, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	13 mo.
Due to: Other conditions: Arteriosclerotic heart disease	11 yrs.
Due to: Cardiac Asthma	8 yrs
Due to: Emphysema	? 8 yrs?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed 12/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1310 11476

Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince George's
City or town Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Prince Geo.
City or town Seat Pleasant
(If outside city or town limits, write RURAL and give nearest town)
Street No. 218 Carmody Hill Dr.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME OLIVER EUGENE CRAMPTON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Minnie M. Crampton
6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Jan. 21- 1883

8. AGE: Years 64 | Months 10 | Days | If less than one day ... hrs. ... min.

9. Birthplace Maryland (town, county, and state)
10. Usual occupation none
11. Industry or business none

FATHER
12. Name Isaac Crampton
13. Birthplace Maryland.

MOTHER
14. Maiden name Anna Ecton
15. Birthplace Maryland.

16. Interment Mrs Minnie M. Crampton
Address 218 Carmody Hill Dr. Seat Pleasant, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-4-47 (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location Bladensburg. Md.
18. Funeral director W. W. Chambers Co.
Address 517 11th St S.E.

19. Dec. 2 1947 Carrie F. Campbell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1st 1947, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death Acute Congestive heart failure	
Due to Cardiovascular-renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

Deputy medical Examiner
23. SIGNATURE John M. Booth M. D. or Other
Address Prestfield Md. Date signed 12-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11477

Reg. Dist. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Camp Springs
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Five (5) Months

Hospital, institution, or street address where death occurred:
Andrews Army Air Field

How long in hospital or institution? ----------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: California County: Solano

City or town: Vallejo
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 104 Chabot Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: CURTIS, CARL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: SYLVIA CURTIS

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 26, 1922

8. AGE: Years	Months	Days	If less than one day
25	3	14	..... hrs. ..... min.

9. Birthplace: Kansas
(Town, county, and state)

10. Usual occupation: 2nd Lt. U. S. Army

11. Industry or business

FATHER — 12. Name:

FATHER — 13. Birthplace

MOTHER — 14. Maiden name:

MOTHER — 15. Birthplace

16. Informant: Next of Kin

Address: Andrews Field.

17. Burial, cremation, or removal. Which?: Burial Date thereof: 12/15/47 (month) (day) (year)

Cemetery or crematory: San Diego Calif.

Location: [illegible]

18. Funeral director: [illegible]

Address: [illegible]

19. Dec. 12 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 December 1947, at 1825 hrs

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..., to ..... 19...

and that I last saw h... alive on ..... 19...

Immediate cause of death	DURATION
Crushing injuries to head and chest, 3d degree burns, all surfaces entire body.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 10 Dec 47

Where did injury occur? Andrews Field. (City or town) Prince Georges (County) Cnty. (State)

Injured at home, farm, industry, public place (where?): See above

Means of injury: Airplane Accident Injured at work?

23. SIGNATURE: Francis E. Barry
FRANCIS E. BARRY 1st Lt MC (M.D. or other)

Address: Andrews Field, Maryland Date signed: 10 Dec 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1572 11478 231

Reg. Diat. No.

1. PLACE OF DEATH: Prince Georges Co.
County
City or town: Ardmore Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges Co
City or town: Quantico Va
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Quarters T
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Christine Holland Slay

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 23, 1947.

8. AGE: Years | Months: 7 | Days | If less than one day: hrs. min.

9. Birthplace: Va
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Merville Marvin Slay
13. Birthplace: Indiana

MOTHER
14. Maiden name: Norma Johnson
15. Birthplace: Va

16. Informant: Mrs. Merville Slay
Address: Quantico Va

17. Buride (Burial, cremation, or removal, Which?) Date thereof: Dec 19, 1947 (month) (day) (year)
Cemetery or crematory: Arlington Cemetery
Location: Arlington Va

18. Funeral director: F Gaeste Sons
Address: Hyattsville Md.

19. 12/19 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 16 19 47 at 4:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 11 19 47 to Dec 16 19 47
and that I last saw h[illegible] alive on Dec 15 19 47

Immediate cause of death: Microcephalus — DURATION: 7 mo.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John D. Maloney M.D.
M.D., or other
Address: Cheverly Md Date signed: 12-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1312

11479

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George8s
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3hrs.55min.
Hospital, institution, or street address where death occurred:
Pr. Geo.Gen'l
How long in hospital or institution? 3hrs. 55min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. Geo.
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6114 42nd Place
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Dickinson, Dr. James

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Anna Mary Dickinson
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 17-1880

8. AGE: Years	Months	Days	If less than one day
67			____ hrs. ____ min.

9. Birthplace: England
(Town, county, and state)

10. Usual occupation: Organist

11. Industry or business: Catholic University

FATHER
12. Name: John Dickinson
13. Birthplace: England

MOTHER
14. Maiden name: Mary G. Haskin
15. Birthplace: England

16. Informant: Anna Mary Dickinson
Address: 6114-42nd Pl. Hyattsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/9/47 (month) (day) (year)
Cemetery or crematory: Mt. Hirst Cemetery
Location: Wash. D.C.

18. Funeral director: W.W. Chaney & Sons
Address: Riverdale Md.

19. 12/6 (Date rec'd by registrar) 19 47 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-5- 19 47 at 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 8-7-47 19 to 12-5 19 47
and that I last saw h[illegible] alive on 12-5-47 19

Immediate cause of death	DURATION
Cerebral Vascular accident	
Due to: Hypertensive Heart disease.	
Due to: Chronic Glomerular Nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: Hypertensive Heart disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: John P. Clum M.D. M. D. or other
Address: Hyattsville Md. Date signed 12-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1314 — 11451

Reg. Dist. No. 245

1. PLACE OF DEATH:
County 3700 - 36th Ave
City or town Hyattsville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3½ months
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ... County ...
City or town Same
(If outside city or town limits, write RURAL and give nearest town)
Street No. ...
(If rural, give LOCATION)
2.(a) If veteran, name war ...

3.(a) FULL NAME CAROLINE ELIZABETH DUTTON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife Walton F. Dutton / Edwin F. Dutton
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) April 24, 1878

8. AGE: Years	Months	Days	If less than one day
69			...hrs. ...min.

8. Birthplace Md. (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name William F. Simpson
13. Birthplace Md.

MOTHER
14. Maiden name Aridena Walker
15. Birthplace Va.

16. Informant Edwin F. Dutton
Address 508 B. St N.E DC.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 20, 1947 (month) (day) (year)
Cemetery or crematory Holy Ghost Am.
Location Issue Md

18. Funeral director W. Warren Talbert
Address 3619-14th St NW DC

19. Dec. 18 1947 (Date rec'd by registrar) Mae Jean Severe, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1947, at 10:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 17 1945, to Dec. 17 1947 and that I last saw h... alive on December 17, 1947

Immediate cause of death	DURATION
Cerebral accident	10 Days
Due to Chronic cardio vascular renal disease	10 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE L. Louis Mandel, M.D.
M. D. or other
Address College Park Md Date signed 12/17/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11481

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos., 12 days

Hospital, Institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 6 mos., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 2205 - L. St., N. W. (If rural, give LOCATION)

2.(a) If veteran, name war: √

3.(a) FULL NAME: BENJAMIN ELLIS

3.(b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Marie Twiman Hunter Ellis

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): October 15, 1882

8. AGE: Years	Months	Days	If less than one day
65 65	2	2	hrs. min.

9. Birthplace: Orange, Virginia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: - - - -

FATHER — 12. Name: Harrison Ellis

13. Birthplace: Orange, Virginia

MOTHER — 14. Maiden name: Lucy Taylor

15. Birthplace: Orange, Virginia

16. Informant: Deceased

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Dec. 18, 1947 (month) (day) (year)

Cemetery or crematory:

Location: to Washington, D. C.

18. Funeral director: George B. Clarke

Address: 1416 Fla. ave. N.E.

19. Dec. 18, 1947 (Date rec'd by registrar) Rowland L. Philips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 17 1947 at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 1947 to Dec. 17 1947 and that I last saw h... alive on Dec. 17 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Md. Date signed: 12/17/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

11482

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs., 6 mos., 4 days

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 11 yrs., 6 mos., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3023 - 14th St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME OLE ERIKSEN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: - - -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 31, 1905

8. AGE: Years	Months	Days	If less than one day
42	1	7	hrs. min.

9. Birthplace: Norway
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: - -

FATHER
12. Name: Knute Eriksen
13. Birthplace: Norway

MOTHER
14. Maiden name: Sina Simansim
15. Birthplace: Norway

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 11, 1947 (month) (day) (year)

Cemetery or crematory: Washington National Cemetery

Location: Prince George's Co., Md.

18. Funeral director: W. W. Chambers Co.

Address: 1400 Chapin St. N.W.

19. Dec. 9, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 8, 1947 at 10.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3, 1936 to Dec. 8, 1947 and that I last saw him alive on Dec. 8, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	16 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 12/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

138 11483

Reg. Dist. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos., 25 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 4 mos., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 628 Callan St., N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: EVANS, CLARENCE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: — — —

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 20, 1920

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
27	6	17		

9. Birthplace: Shelton, North Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: — — —

FATHER
12. Name: Donnie Evans
13. Birthplace: Shelton, North Carolina

MOTHER
14. Maiden name: Mamie Richardson
15. Birthplace: Shelton, North Carolina

16. Informant: Deceased
Address

17. Removal for Burial
(Burial, cremation, or removal. Which?) Date thereof: Dec 8 47
(month) (day) (year)

Cemetery or crematory: Payne Cemetery

Location: Washington, DC

18. Funeral director: J T Stewart

Address: 30 H St ne

19. Dec 8, 1947 (Date rec'd by registrar) Rowland S Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 7, 1947, at 5:18 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/9 1947, to 12/7 1947 and that I last saw h. im alive on 12/7 1947.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	9 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed: 12/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11484

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 7 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 816 K. Street, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: SHERMAN FREDERICK

3.(b) Social Security Number: 577-05-5748

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Separated

6.(b) Name of husband or wife: Clara Sherman

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): July 3, 1907

8. AGE: Years	Months	Days	If less than one day
40 40	5	3	..... hrs. ..... min.

9. Birthplace: Hoboken, New Jersey
(Town, county, and state)

10. Usual occupation: Construction carpenter

11. Industry or business: - - -

FATHER
12. Name: Frederick W. Sherman
13. Birthplace: ? New Jersey

MOTHER
14. Maiden name: Madeline Schluetter
15. Birthplace: ? New Jersey

16. Informant: Deceased
Address

17. removal Date thereof: Dec. 7 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Washington, D. C.

Location

18. Funeral director: W. W. Chambers Co.

Address: 517 - 11th St., S.E., Wash., D. C.

19. 12-7-1947 Rowland S. Phibbs
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 6, 1947, at 7 25 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/5 1947, to 12/6 1947

and that I last saw h. alive on 12/6 1947

Immediate cause of death	DURATION
pulmonary tuberculosis	5 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 12/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1312

11485

R 245

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Prince George's

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Dead on arrival

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1008 West Cross.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Thomas Gibson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Lilly Gibson

6.(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): Sept 9, 1884

8. AGE: Years: 63 Months: Days: If less than one day: hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Foreman

11. Industry or business: Paper Box Factory

FATHER — 12. Name: Henry Gibson

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Lucy Talbert

15. Birthplace: Virginia.

16. Informant: Lilly Gibson

Address: 1008 West Cross St. Baltimore Md

17. transportation (Burial, cremation, or removal—Which?) Date thereof: Dec 30, 1947 (month) (day) (year)

Cemetery or crematory: Chatham

Location: Va

18. Funeral director: F Geschickson

Address: Hyattsville Md.

19. 12/30 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 29 1947 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy medical examiner James J. Ford, M. D. or other

Address: Hyattsville Md Date signed: 12-29-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1200

CERTIFICATE OF DEATH

11486 Reg. Dist. No. 345

1. PLACE OF DEATH:
County Prince Georges
City or town Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or institution? 20 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Kenilworth, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4907 Addison Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Katherine C. Gibson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Mr. Thomas S.
6.(c) If alive, give age 27 years
7. Birth date of deceased (mo., day, yr.) 1-13-1910

8. AGE: Years	Months	Days	If less than one day
37	11	3	hrs. min.

9. Birthplace St. Louis, Missouri (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Mr. Isaac Nicholas
13. Birthplace Elizabeth, New Jersey

MOTHER
14. Maiden name Miss Elizabeth Lepping
15. Birthplace St. Louis, Missouri

16. Informant Mr. Thomas Gibson
Address 4907 Addison Rd, Kenilworth, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 19 1947 (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery
Location Suitland Maryland
18. Funeral director Hanlon Funeral Home
Address 641-H St. N.E. Washington D.C.

19. Dec. 16 1947 Mrs. Jas. Devere Deputy local registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1947 at 9 55 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-14 1947 to 12-16 1947 and that I last saw h... alive on 12-16 1947

	DURATION
Immediate cause of death Uterus	
massive gastrointestinal hemorrhage	2 days
Due to acute Enteritis.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dayton O Watkins MD
M. D. or other
Address 5306 Annapolis Rd Date signed 12-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

11487

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Prince Georges Co
City or town: Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Twenty-two
Hospital, institution, or street address where death occurred: 4637 - 42nd Place
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prd Geo Co
City or town: Hyattsville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4637 - 42nd Place
(If rurol, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Augustus Rossell Glasgow

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lena J. Glasgow
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Feb 22, 1882

8. AGE: Years	Months	Days	If less than one day
65	9	18	..... hrs. ..... min.

9. Birthplace: Washington D. C. (Town, county, and state)
10. Usual occupation: Business Man
11. Industry or business: Several

FATHER
12. Name: Augustus Rossell Glasgow
13. Birthplace: Washington D.C.

MOTHER
14. Maiden name: Miss Mary A Daly
15. Birthplace: Washington D.C.

16. Informant: Raymond F. Glasgow
Address: 4637 42nd Place, Hyatts. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 22, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md

18. Funeral director: F Gaschè sons
Address: Hyattsville Md.

19. Dec 22 1947 (Date rec'd by registrar) James Berry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 15 1947 at 12 15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1941 to Dec 15 1947
and that I last saw him alive on Dec 15 1947

Immediate cause of death: Coronary Thrombosis — DURATION: 18 hrs
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Truman Hays M. D. or other
Address: Hyatts. Md Date signed 12-20-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11488

830

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Pr. Georges County
City or town: Seat Pleasant Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 Hours
Hospital, institution, or street address where death occurred:
500 ADDISON RD.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr Geo Co
City or town: Capitol Heights Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George Dallas Grant

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Sarah Elizabeth Grant
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 31 1866

8. AGE: Years	Months	Days	If less than one day
81			hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Retired huckster (Produce)
11. Industry or business

FATHER
12. Name: Albert D Grant
13. Birthplace: Scotland

MOTHER
14. Maiden name: Sarah N. Kingsbury
15. Birthplace: Meadows Pr Geo Co Md.

16. Informant: Mrs Margaret Halfpap
Address: 500 Addison Rd Seat Pleasant Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-4-47 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md.

18. Funeral director: W.H. Lamb's Co.
Address: 5th-11th St. S.E. Wash. D.C.

19. Dec. 3 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1st 1947, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 12 1947, to Dec 1 1947
and that I last saw him alive on November 29 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	24 hours
Due to: arteriosclerosis	20 Hours History
Due to: senility	
Other conditions: Fracture of left hip on Sept 12 1947 (Not contributory)	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. Suit Ritchie M.D.
M. D. or other
Address: 6906 Ritchie Rd S.E. Washington 19 D.C. Date signed: Dec 1 1947

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11489

138

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2024 Monroe St., N. E.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: THOMAS J. HALLERAN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Sarah Halleran

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 21, 1884

8. AGE: Years	Months	Days	If less than one day
63 63	9	7	hrs. min.

9. Birthplace: ? Illinois

(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: - - - -

FATHER

12. Name: Thomas Halleran

13. Birthplace: ?

MOTHER

14. Maiden name: Sarah Stevenson

15. Birthplace: ?

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 30, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Washington, D.C.

18. Funeral director: Lee Funeral Home

Address: 300-4th St. N.E., Washington D.C.

19. Dec 30, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 28 1947 at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/20 1947, to 12/28 1947

and that I last saw h...i...m...alive on Dec 28 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis.	9 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale, Md. Date signed: 12/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

11490

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:
County: Prince George
City or town: Laurel maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months 5 days
Hospital, institution, or street address where death occurred:
Laurel Sanitarium
How long in hospital or institution? 4 months 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: maryland County: montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7400 Bradley Blvd.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JOHN J HAMILTON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	widower

6.(b) Name of husband or wife: Nanny Kerr
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept 25 - 1869

8. AGE:

Years	Months	Days	If less than one day
78	2	24	20 hrs. 04 min.

9. Birthplace: maryland (Town, county, and state)
10. Usual occupation: Attorney
11. Industry or business
FATHER 12. Name: Francis P. Hamilton
13. Birthplace: md.
MOTHER 14. Maiden name: Pricilla neal
15. Birthplace: maryland.
16. Informant: Records. Sanitarium
Address: Laurel Md
17. Removal (Burial, cremation, or removal. Which?) Date thereof ____ (month) (day) (year)
Cemetery or crematory: Wash. D. C.
Location: ____
18. Funeral director: Joseph Gawler's Sons
Address: 1756 Pa. Ave. N.W. Wash. D.C.
19. Dec 20 1947 M. Brashears (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-19 1947, at 8.04 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 14 1947, to December 19 1947
and that I last saw him alive on December 19 1947

Immediate cause of death	DURATION
myocardial Failure	
Due to: Arterio-sclerosis	
Due to: Senility	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury: ____ Injured at work?

23. SIGNATURE: Jesse D Capps M.D.
M. D. or other
Address: Laurel Sanatarium Laurel md. Date signed 12/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

11491

CERTIFICATE OF DEATH

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Hyattsville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Sacred Heart Home

Stay in hospital or inst. (yrs., or mos., or days): 1 year 11 months

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

P6

State: Maryland County:

City or town: Hyattsville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Maria A. Hausler

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Frank Hausler

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 15, 1856

8. AGE: Years	Months	Days	If less than one day
91			hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: George Scheiringer

13. Birthplace: Germany

MOTHER — 14. Maiden name:

15. Birthplace:

16. Informant: Joseph A. Hausler

Address: 3728 Morrison St N W

17. Burial (Burial, cremation, or removal. Which?) Date thereof: December 23 1947 (month) (day) (year)

Cemetery or crematory: St Marys Cemetery

Location: Washington D.C.

18. Funeral director: Frank Leiers Sons Co

Address: 3605-14 St N W Wash. D.C.

19. Dec 21 1947 (Date rec'd by registrar) Mrs Jas. Devere Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 21 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1947, to Dec 21 1947, and that I last saw h- alive on Dec 21 1947.

	DURATION
Immediate cause of death: Cerebral Thrombosis	Months
Due to: Nephritis Sclerosa	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J Clarke Ryder M D

M. D. or Other

Address: 35 N.Y. Ave Date signed: Dec 24 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

836

11492

Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince George.
City or town Hilside, M.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 years.
Hospital, Institution, or street address where death occurred:
1306-57th Ave. Hilside, Md.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Prince George.
City or town Hilside.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1225-55th Ave. Hilside, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Agnes S. Hayes.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife Charles A. Hayes.
6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) April 26, 1872.

8. AGE:

Years	Months	Days	If less than one day
75	7	17	hrs. min.

9. Birthplace Germany.
(Town, county, and state)
10. Usual occupation House Wife.
11. Industry or business
FATHER 12. Name — Lithia
13. Birthplace Germany.
MOTHER 14. Maiden name Unk
15. Birthplace Germany.
16. Informant Charles A. Hayes.
Address 1225-55th Ave. Hilside, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-16-47 (month) (day) (year)
Cemetery or crematory Episcopal Church Cemetery
Location Forestville Maryland.
18. Funeral director W. W. Chambers Co.
Address 517-11th St. S.E.
19 Dec. 13 (Date rec'd by registrar) 19 47 Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13 19 47, at 3:20 P. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 4 19 47, to December 13 19 47
and that I last saw h... alive on December 13 19 47
Immediate cause of death Coronary Thrombosis — DURATION 3 wks
Due to Generalized Arteriosclerosis — 10 years
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William Brannin M. D. or Coroner
Address Capitol Hgts, Md Date signed 12/13/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

1149 3

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: P. G. Geo County
City or town: Mitchellville, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 46 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: P G Geo
City or town: Mitchellville, Md - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Queenanne
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Jane Barbara Rogers Heathcote

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	M.

6.(b) Name of husband or wife: Earl Heathcote
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): July 17 1893

8. AGE:

Years	Months	Days	If less than one day
54	4	17	hrs. min.

9. Birthplace: Bangor Maine
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Willett Hicks Rogers
13. Birthplace: York

MOTHER
14. Maiden name: Nellie Maude Ingalls
15. Birthplace: Alabama

16. Informant: Evelyn Heathcote Farris
Address: Mitchellville, Md

17. buried — Date thereof: Dec 9 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Mount Oak
Location: Mitchellville Md
18. Funeral director: Clarence Foreacre
Address: Mitchellville Md

19. 12 7 47 — Louise H Peach
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 Dec 1947 at 1 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1947 to 6 Dec 1947 and that I last saw h.. alive on 6 Dec 47 1947

Immediate cause of death	DURATION
Coronary Thrombosis	6 hrs.
Due to: Arteriosclerotic C V Disease	Unk.
Due to:	
Other conditions: Diabetes Mellitus	Unk.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert B Fraser M. D.
Address: Upper Marlboro, Md Date signed: 7 Dec 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11494

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Pro Geo Co
City or town Hyattsville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Pro Geo Co.
City or town Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4108 – Longfellow st
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Martha ann Hoopes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife Francis Hoopes
6.(c) If alive, give age 79 years
7. Birth date of deceased (mo., day, yr.) June 1. 1866

8. AGE: Years 81 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Pa (Town, county, and state)
10. Usual occupation housewife
11. Industry or business
FATHER 12. Name Daniel Wickes
13. Birthplace Pa
MOTHER 14. Maiden name Elizabeth Gibbins
15. Birthplace Pa
16. Informant Francis Hoopes
Address Hyattsville Md
17. Disposition Transportation (Burial, cremation, or removal. Which?) Date thereof Dec 28, 1947 (month) (day) (year)
Cemetery or crematory Arlington Cemetery
Location Ardmore Pa
18. Funeral director L Gaschs sons
Address Hyattsville Md.
19. Dec. 26 19 47 (Date rec'd by registrar) Mrs Jas. Devereux Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25, 1947, at 10.45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2 1944, to Dec 25 1947
and that I last saw h.e alive on Dec. 24 1947

Immediate cause of death	DURATION
Coronary-thrombosis	
Renal Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Albert Gill MD M. D. or other
Address Hyattsville Md Date signed 12-26-47

PLEASE WRITE PLAINLY, WITH LIKFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

108 11495

Reg. Diat. No. 230

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: PRINCE GEORGES
City or town: R.F.D. 2 LAUREL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Days
Hospital, institution, or street address where death occurred: CONTEE M. Cir GUNPOWDER Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: PRINCE GEORGES
City or town: R.F.D. 2 LAUREL
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mr. WILLIAM HARVEY Jack

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mertie M. Jack
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 9, 1866

8. AGE:

Years	Months	Days	If less than one day
81	0	14	hrs. min.

9. Birthplace: Clinton Penna. (Town, county, and state)
10. Usual occupation: Retired Carpenter
11. Industry or business: Carpenter

FATHER
12. Name:
13. Birthplace: Penna

MOTHER
14. Maiden name: Greer
15. Birthplace: Penna.

16. Informant: Leslie Jack
Address: Route 2, Laurel, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 26 1947 (month) (day) (year)
Cemetery or crematory: Washington National Cemetery
Location: Suitland Road & P.G. Co.

18. Funeral director: [illegible]
Address: 1546 Good Hope Rd. S.E.

19. Dec 23rd 1947 (Date rec'd by registrar) John D. Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 23 1947 at 1:02 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 1947, to Dec 23 1947 and that I last saw h.i.m. alive on Dec 23 1947

Immediate cause of death	DURATION
Lobar pneumonia	1 day
Due to	
Due to	
Other conditions: Cerebral hemorrhage	several years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John N. Andrews M.D. M. D. or other
Address: 9601 Colesville Rd Silver Spring Md. Date signed: Dec 23-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

11496

Reg. Diat. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County PRINCE George's

City or town Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hrs - 5 min

Hospital, Institution, or street address where death occurred:

Prince George's General Hospital

How long in hospital or institution? 3 hrs - 5 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Colmar Manor

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3505 - 37th Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME J. Irving Jarboe

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mrs. Bertha Jarboe

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 2 - 10 - 1884

8. AGE: Years	Months	Days	If less than one day
63	10	6	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation manager business

11. Industry or business A & P Tea Company

FATHER 12. Name John Samuel Jarboe

FATHER 13. Birthplace Mechanicsville, Md.

MOTHER 14. Maiden name Eliza McKee

MOTHER 15. Birthplace Nottingham, Prince Georges Co Md.

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 - 19 - '47 (month) (day) (year)

Cemetery or crematory Ft. Lincoln Cem.

Location Bladensburg Rd Prince Georges County

18. Funeral director The S. H. Hines Co.

Address 2901 - 14th St. N.W.

19. 12/17 1947 Amanda Downey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16 1947 at 5:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-16 1947, to 12-16 1947

and that I last saw h. alive on 12-16 1947

Immediate cause of death	DURATION
Rupture of Left Ventricle & Pericardial Hemorrhage	10 hrs.?
Due to Cause Unknown	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Some Further Study to be made

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. B. Morgan M.D. M. D. or other

Address Nat. Rainier Md Date signed 12-17-47

11497

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Bradbary Heights
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, institution, or street address where death occurred:
4901 S St SE (home)

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County: Morgan

City or town: Berkeley Springs (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Daniel Johnson

3.(b) Social Security Number: 234-36-5971

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 21, 1889

8. AGE: Years	Months	Days	If less than one day
58	3	15	..... hrs. ..... min.

9. Birthplace: Berkley Springs, Morgan Co, W Va
(Town, county, and state)

10. Usual occupation: Electrician

11. Industry or business

FATHER
12. Name: George Johnson
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Margaret Shriver
15. Birthplace: West Virginia

16. Informant: Mrs. Ratt Bird

Address: 4901 S. St. S.E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/9/47 (month) (day) (year)

Cemetery or crematory: GREEN-WAY -

Location: BERKELEY SPRINGS, W. VA

18. Funeral director: L. H. Chambers Co

Address: 5711 Ga Ave

19. Dec. 7 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 6 19 47, at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 10, 1947, to December 6, 1947 and that I last saw h.y.m. alive on December 6 1947

Immediate cause of death	DURATION
Pulmonary tuberculosis, Bilateral	Not known
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Emmett E. Cornelson M.D.
M. D. or other

Address: 4100 Bowen Rd. S.E. Date signed Dec 6, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Contract Ave Meadowbrook.
Wm. Campbell.

11498

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93e

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County Pro Geo Co
City or town 4006 Madison St Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Pro Geo
City or town Hyattsville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4006 Madison St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Nelson Thompson Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife: Cynthia Johnson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 8, 1863-

8. AGE: Years: 84 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maine (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business

FATHER
12. Name: Joseph L. Johnson.
13. Birthplace: Maine

MOTHER
14. Maiden name: Sarah Tippett
15. Birthplace: Maine

16. Informant: Cynthia Schott
Address: Hyattsville Md

17. Burial, cremation, or removal. Which?: transportation Date thereof: Dec 13, 1947 (month) (day) (year)
Cemetery or crematory: Beaver Cemetery
Location: East Bridge Waterford Mass.

18. Funeral director: E Gaschis sons
Address: Hyattsville Md.

19. Dec 13 1947 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 12, 1947, at 9.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 26 1947 to Dec 12 1947 and that I last saw h.. alive on 12-10 1947

Immediate cause of death	DURATION
Myocarditis	4 wks
Due to: Age	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Gerard Hays M. D. or other
Address: Hyatts. Md Date signed 12-13-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

11500

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

Reg. Diat. No. 242

1. PLACE OF DEATH:
County: Prince George's
City or town: Suitland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
4813 Suitland Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Suitland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4813 Suitland Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Eugene Emanuel Jones

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary Jane Jones
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 2, 1872

8. AGE: Years: 75 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Farm

FATHER
12. Name: J. B. Jones
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Eugene Olen Jones
Address: 316 9th Street N.E., Wash. D.C.

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) 12-5-47
Cemetery or crematory: Glenwood
Location: Washington, D.C.
18. Funeral director: W. W. Chambers & Co
Address: 517-11 st SE

19. (Date rec'd by registrar) Dec. 3 1947 Carrie J. Campbell, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1 1947 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: acute congestive heart failure	
Due to: Cardiovascular renal disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Deputy Medical Examiner
23. SIGNATURE: [signature] M. D. or other
Address: Forestville, Md. Date signed: 12/1/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct Age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157a

11511

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince Georges

City or town: Chapel Oaks

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, institution, or street address where death occurred:

1404-57th Place

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Chapel Oaks

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1404-57th Place

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sharley Anne Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1947

8. AGE: Years | Months: 5 | Days: 2 | If less than one day: hrs. min.

9. Birthplace: Chapel Oaks, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: George T. Jones

13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Etta Mc Mullen

15. Birthplace: North Carolina

16. Informant: George T. Jones

Address: 1404-57th Place, Chapel Oaks

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 3. 47 (month) (day) (year)

Cemetery or crematory: Parmes

Location: Washington, D.C.

18. Funeral director: Myrtle K. Rollins

Address: 4339 Hunt Pl., N.E.

19. Dec 2 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 1 1947, at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Hydrocephalus — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Deputy Medical Examiner M. D. or other

Address: Beltsville Md. Date signed 12-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate if age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46e

11499

CERTIFICATE OF DEATH

Reg. Dist. No. 248

1. PLACE OF DEATH:

County: Prince George

City or town: Hyattsville Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4409 Beechwood Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Earl S Johnston Md

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Virginia Andes Johnston

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 5th 1889

8. AGE: Years	Months	Days	If less than one day
58			..... hrs. ..... min.

9. Birthplace: Penn. (Town, county, and state)

10. Usual occupation: Cheif of Division Radiation

11. Industry or business: and Organisim U.S. Gov.

FATHER — 12. Name: Rev C B Johnston

13. Birthplace: Penn

MOTHER — 14. Maiden name: Anne Steinford

15. Birthplace: Penn

16. Informant: Mrs Virginia Andes Johnston

Address: 4409 Beechwood Rd. Hyattsville MD

17. (Burial, cremation, or removal. Which?) Date thereof: Dec-19-1947 (month) (day) (year)

Cemetery or crematory: Cremation At Lee,s

Location: Washington D C

18. Funeral director: J Wm Lee Bros Co

Address: 306-4th St N E

19. Dec 18 1947 (Date rec'd by registrar) James Seay Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 17 1947 at 3:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15 1947 to December 17 1947 and that I last saw h.. alive on December 17 1947

Immediate cause of death	DURATION
Respiratory failure	
Due to: Carcinomatosis - involving lungs, liver, bones	
Due to: Carcinoma of the sigmoid.	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank Jaggar M.D. M. D. or other

Address: 5707 Wisconsin Ave. Date signed: 12/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

830a

115112

Reg. Dist. No. 234

1. PLACE OF DEATH:

County: Prince Georges Co

City or town: Oxon Hill Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges Co

City or town: Oxon Hill Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7300 - Oxon Hill Rd S E.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary J. Kerby

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widowed

6.(b) Name of husband or wife: John H. Kerby

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 5 - 1860

8. AGE: Years: 87 Months: 11 Days: 16 If less than one day: ..... hrs. ..... min.

9. Birthplace: Charles Co., Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: William A. Mudd

13. Birthplace: Charles Co. Maryland

MOTHER — 14. Maiden name: Anne Tennick

15. Birthplace: Charles Co, Maryland

16. Informant: Miss Grace Kerby

Address: 7300 - Oxon Hill Rd S E Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 22 - 1947 (month) (day) (year)

Cemetery or crematory: St Johns Episcopal Ch

Location: Broad Creek, Maryland

18. Funeral director: Arthur E. Simms Jr

Address: 2007 - Nichols Ave S.E.

19. Dec 20 47 (Date rec'd by registrar) Harold Buell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 19 1947 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 18 1947 to Dec 19 1947 and that I last saw her alive on Dec 18 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to: General Arteria Sclerosis	uncertain
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Dane Ethan Yaffee M.D. M. D. or other

Address: Washington 19 D.C. Date signed: Dec 20 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11503

50

CERTIFICATE OF DEATH

Reg. Diat. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Pr. Geo.
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24days
Hospital, institution, or street address where death occurred:
Pr. Geo. Gen'l
How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Pr. Geo.
City or town Suitland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2718 43rd Place
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Kersey, Mrs. Katherine

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 29-1877

8. AGE:	Years	Months	Days	If less than one day
	69			..... hrs. ..... min.

9. Birthplace Va.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name James Bradley
13. Birthplace Cork, Ireland

MOTHER
14. Maiden name Katherine Rainey
15. Birthplace Cork, Ireland

16. Informant Mrs. Irene Eagleston
Address 2718 43rd Place, Suitland, Md.

17. Removal Date thereof 12/29/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory
Location Washington, D.C.

18. Funeral director W. W. Chambers
Address 517 - 11th St SE.

19. 12/29 1947 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29- 1947, at 12:20a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 5 1947, to Dec 29 1947
and that I last saw her alive on Dec 28 1947

Immediate cause of death	DURATION
generalized Carcinomatosis	5 mo.
Due to Carcinoma of Breast	10 Years
Due to	
Other conditions Coronary arteriosclerotic Heart Disease	1 Year

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Samuel J. N. Sugar M.D.
M.D., or other
Address Mt Rainier, Md Date signed Dec 29, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

462 11504

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George's

City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 days

Hospital, institution, or street address where death occurred:
Prince George's General Hospital

How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Colmar Manor
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3404 39th Place
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Kestler, Mr. Albert C.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 3, 1906

8. AGE: Years	Months	Days	If less than one day
41			..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name Kestler, Mr. Harry

13. Birthplace Washington D.C.

MOTHER 14. Maiden name agnes Keck

15. Birthplace Pa

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 8. 1947 (month) (day) (year)

Cemetery or crematory Ft. Lincoln Cemetery

Location Washington D.C.

18. Funeral director L. Deschamps & Sons

Address Hyattsville Md

19. Dec 4 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-3 - 1947 at 6:07a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1947 to Dec 3 1947 and that I last saw h.. alive on Dec 3 1947

Immediate cause of death adenocarcinoma of Rectum — DURATION 4+ mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results adeno carcinoma of Rectum

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Samuel J. Kluger MD
M. D. or other

Address Mt. Rainer, Md. Date signed Dec 3, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for the change of date of birth is shown on G 114 1/13/48 pc

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

11505

Reg. Diat. No. 245

1. PLACE OF DEATH:
County: Prince George's
City or town: West Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred: 3112 Kimberley Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. Geo.
City or town: West Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3112 Kimberley Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: VIOLA Elizabeth King

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband ~~or wife~~: Maurice Henry King
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Sep. 5, 1889 1888

8. AGE: Years	Months	Days	If less than one day
59 ~~58~~	3	20	hrs. min.

9. Birthplace: Washington DC (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: "

FATHER
12. Name: Charles E. Hoover
13. Birthplace: Wash DC

MOTHER
14. Maiden name: Ida Bladen
15. Birthplace: Wash DC

16. Informant: Maurice H. King
Address: 3112 Kimberly Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 29/47 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln Cemetery
Location: Colmar Manor Md.

18. Funeral director: L.H. Hines Co
Address: 2901-14th N W Wash D.C.

19. Dec. 25th 1947 (Date rec'd by registrar) Mrs. Ina Devere Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 25 1947 at 4:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1947 to Dec 25 1947 and that I last saw her alive on Dec 23 1947

Immediate cause of death	DURATION
myocardial Infarction	6 weeks
Due to: Coronary Heart Disease	5 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Samuel J N Sugar M.D. M. D. or other
Address: Mt. Rainier, Md. Date signed: 25 Dec 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

11506

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one day

Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? One day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 523 - Third St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: LEAKE, PERCY EARL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Marie Anderson Leake

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 4, 1872

8. AGE: Years	Months	Days	If less than one day
75 75	1	2	..... hrs. ..... min.

9. Birthplace: Memphis, Tennessee
(Town, county, and state)

10. Usual occupation: Utility Work

11. Industry or business: - - -

FATHER
12. Name: Samuel J. Leake
13. Birthplace: ? Virginia

MOTHER
14. Maiden name: Helen Boyd
15. Birthplace: ? Virginia

16. Informant: Deceased

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12/8/47 (month) (day) (year)

Cemetery or crematory:

Location: to D.C. Morgue, D.C.

18. Funeral director: Daniel Leo Finucane, Supt.

Address: Glenn Dale Sanatorium, Glenn Dale, Md.

19. Dec. 8, 1947 (Date rec'd by registrar) Rowland S. Phibbs (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 6, 1947, at 5 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/5 1947 to 12/6 1947

and that I last saw h[illegible] alive on 12/6 1947

Immediate cause of death	DURATION
pulmonary tuberculosis	6 wks?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed 12/6/47

W

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11507

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Georges
City or town: Bladensburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 yrs.
Hospital, institution, or street address where death occurred:
4701 47th st.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Bladensburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4701 47th st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MARY LEE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 15, 1881

8. AGE: Years: 66 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Bladensburg, Md.
(Town, county, and state)

10. Usual occupation: At home

11. Industry or business

FATHER
12. Name: --- Lee
13. Birthplace: Md.

MOTHER
14. Maiden name: ---------
15. Birthplace: Md.

16. Informant: Malinda Brown
Address: 4701 47th st., Bladensburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/12/47 (month) (day) (year)
Cemetery or crematory: Methodist Cemetery
Location: Bladensburg, Md.
18. Funeral director: J. Dardis Sons
Address: Hyattsville, Md.

19. 12/11/47 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 9 19 47 at 12 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 5 19 47 to Dec 9 19 47
and that I last saw h... alive on Dec 7 19 47

Immediate cause of death	DURATION
Chronic Endocarditis	2 yrs.
Due to Bronchial Asthma	2 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: William A. Deale Jr. M.D.
M. D. or other
Address: 1161 First St. Hyattsville Md. Date signed Dec 10/47

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11508

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos., 16 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 4 mos., 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 421 - Q. Street, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: FRANK LITTLE

3.(b) Social Security Number: 579-05-3229

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Helen Little

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): April 29, 1903

8. AGE: Years	Months	Days	If less than one day
44	7	16	....hrs. ....min.

9. Birthplace: Waynesboro, North Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: - - -

FATHER
12. Name: Samuel Little
13. Birthplace: ? North Carolina

MOTHER
14. Maiden name: Cora Tyson
15. Birthplace: ? North Carolina

16. Informant: Deceased

Address

17. removal (Burial, cremation, or removal. Which?) Date thereof Dec. 15 1947 (month) (day) (year)

Cemetery or crematory: Washington D.C.

Location

18. Funeral director: Malvaux & Sickey Inc

Address 424 R. St. N.W.

19. Dec. 15 1947 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 15, 1947 at 4:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28, 1947, to Dec. 15, 1947 and that I last saw h.. alive on Dec. 14, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	7 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed 12/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

11509

Reg. Diat. No. 245

1. PLACE OF DEATH:

County: Prince George

City or town: Hyattsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: Hyattsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4012-30th. St. N.E. Hyts, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Anna Ellen Lyons

3. (b) Social Security Number: 578-32-3140

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 24, 1873

8. AGE: Years	Months	Days	If less than one day
74			hrs. min.

9. Birthplace: Oklahoma (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: U.S. Government

FATHER

12. Name: Lyons

13. Birthplace: Canada

MOTHER

14. Maiden name: Meggs

15. Birthplace: Oklahoma

16. Informant: Mrs. LaFrance

Address: 4012 --30th. St. N.E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 23, 1947 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln, Cem.

Location: Md.

18. Funeral director: The S. E. Nairn Co.

Address: 2901-14th St. N. W. Wash. D.C.

19. Dec. 20 1947 Mrs. Jas. Devere Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 20 1947, at 1a M

21. I CERTIFY that death occurred on the date above stated: I had attended deceased from Oct 10 1947 to Dec 20 1947 and that I last saw her alive on Dec 18 1947

Immediate cause of death	DURATION
Carcinoma brain	3 mos
Due to: Metastasis from Carcinoma breast	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D. or other

Address: 2100 N Cap St Wash DC Date signed: 12/22/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

66b 11510

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County Prince George's
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residence of mother)
State Maryland County Prince George's
City or town Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3902 Jefferson
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles L. Martin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Mary Martin
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1907

8. AGE: Years	Months	Days	If less than one day
40	5	28	hrs. min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual occupation Painter
11. Industry or business
FATHER 12. Name Charles L. Martin
13. Birthplace Buchanan, Va.
MOTHER 14. Maiden name Lottie Graves.
15. Birthplace Washington, D.C.
16. Informant Hospital records
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 3, 1948. (month) (day) (year)
Cemetery or crematory Arlington Ma. Cemetery
Location Arlington Va.
18. Funeral director Wm Lee Sons Co
Address 200 4th St N.W.
19. 12/31 1947 (Date rec'd by registrar) Amanda Deurenberg Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30, 1947 19 at 4:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-24-47 19 to 12-30 19 47
and that I last saw h him alive on 12-30-47 19
Immediate cause of death Pre-renal azotemia from Bronchopneumonia

	DURATION
Due to	8 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John P. Cann M.D.
M. D. or other
Address Upper Marlboro Md Date signed 12-31-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

11511

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Georges
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, institution, or street address where death occurred:
Pr. Geo. Genl. Hosp.
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Pr. Georges
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3127 Parkway
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME McCready Mr. John

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3 - 1880

8. AGE: Years 67 Months Days If less than one day hrs. min.

9. Birthplace Frenchtown Pa
(Town, county, and state)

10. Usual occupation Foreman

11. Industry or business D.C. Water

FATHER 12. Name Andrew McCready Pa

13. Birthplace

MOTHER 14. Maiden name Jennie Beare

15. Birthplace Pa

16. Informant Ray McCready

Address 3127 Parkway, Cheverly, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/22/47 (month) (day) (year)

Cemetery or crematory Fort Lincoln Cem.

Location Wash. D.C.

18. Funeral director Mow Chenault Co

Address Brentwood Md.

19. 12/22 19 47 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19 1947, at 3:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 12th 1947, to December 19 1947 and that I last saw him alive on December 18th 1947

Immediate cause of death	DURATION
Coronary thrombosis with myocardial infarction	7 days
Due to Coronary Heart disease	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ronald S. Fleisher M.D.
M. D. or other

Address 5401-35th Ave, Hyattsville Date signed 12-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11512

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County Prince Georges
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Dead on arrival
Hospital, institution, or street address where death occurred:
Prince Georges General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town Calmar Manor
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4207 - Newton Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Gertrude Florence McVay

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1910

8. AGE: Years 37 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Brentwood Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Matthew A. McKeown

FATHER 13. Birthplace Virginia

MOTHER 14. Maiden name Alice Nichols

MOTHER 15. Birthplace Odenton, Md

16. Informant Matthew A. McKeown

Address Brentwood Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 31, 1947 (month) (day) (year)

Cemetery or ~~crematory~~ George Washington

Location Berwyn Md

18. Funeral director F Gaeta's Sons

Address Hyattsville Md.

19. 12/30 19 47 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 19 47 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ...

and that I last saw h ... alive on ... 19 ...

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to Myocardosis	
Due to	
Other conditions Cerebral Embolism, Pneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results Autopsied

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... injured at work?

23. SIGNATURE Deputy Medical Examiner

M. D. or other

Address Brentwood Md Date signed 12-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

11513

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County Prince George
City or town 4803 Woodlawn Drive Landover Hills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mo.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D.C. County Prince George
City or town Landover Hills
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4803 Woodlawn Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME NELLIE PERRY MILLER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	WIDOW.

6.(b) Name of husband or wife RICHARD C. MILLER
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) AUG. 26 1865

8. AGE: Years 82 | Months 4 | Days | If less than one day ... hrs. ... min.

9. Birthplace CLEVELAND, OHIO.
(Town, county, and state)

10. Usual occupation AT HOME

11. Industry or business

FATHER
12. Name WILLIAM H PERRY
13. Birthplace ENGLAND

MOTHER
14. Maiden name HARRIET HANBERRY
15. Birthplace ENGLAND

16. Informant William Perry Miller
Address 4803 Woodlawn Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 27 1947 (month) (day) (year)
Cemetery or crematory Erie
Location Erie Penn

18. Funeral director Jos Gawlas Sons
Address 1756 Penn ave. N.W. Washington

19. Dec 27 1947 (Date rec'd by registrar) James Seney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26-47 19... at 6:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-1-47 19... to 12-26 19 47 and that I last saw her alive on 12-24-47 19...

Immediate cause of death	DURATION
Heart failure	years
Due to Pulmonary Edema	
Due to arteri-sclerotic Heart disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations none
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dayton O Watkins Md
(Physician)
Address 5306 Annapolis Rd, Hyattsville Date signed 12-27-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11514

Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years, 10 months, 17 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 7 years, 10 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1355 You Street, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MONTGOMERY LDA

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: James Montgomery

6.(c) If alive, give age: abut 57 years

7. Birth date of deceased (mo., day, yr.): May 3, 1902

8. AGE: Years	Months	Days	If less than one day
45	7	2	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: - - -

FATHER
12. Name: Wilbur B. Nelson
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Lucy Carpenter
15. Birthplace: Orange, Virginia

16. Informant: Deceased

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof Dec 6, 1947 (month) (day) (year)

Cemetery or crematory

Location: to Washington, D.C

18. Funeral director: W Ernest Jarvis Co.

Address: 1432 You St. N.W. Wash, D.C.

19. Dec 6, 1947 (Date rec'd by Registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 5, 1947 at 5:40 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/17 1940 to 12/5 1947 and that I last saw h.. alive on 12/5 1947

Immediate cause of death	DURATION
pulmonary tuberculosis	12 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Md., Date signed 12/5/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11515

13/a

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 hrs. and 30 min.
Hospital, Institution, or street address where death occurred:
Prince George's General Hospital
How long in hospital or institution? 22 hrs. and 30 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: West Lanham Hills
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5003 W. Lanham Drive
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME
MR. GEORGE H. MORGAN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 16, 1869

8. AGE: Years	Months	Days	If less than one day
78	11	2	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Retired farmer

11. Industry or business

FATHER
12. Name: John Morgan
13. Birthplace: Md

MOTHER
14. Maiden name: Eliza Quade
15. Birthplace: Md

16. Informant: Richard F. Carter (Son-in-law)
Address: 5003 W. Lanham Dr., W. Lanham Hills, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof: (month) Dec (day) 22 (year) 1947
Cemetery or crematory: St Joseph's
Location: Morganza, St Marys Co. Md
18. Funeral director: J. Gasch's Sons
Address: Hyattsville, Md

19. (Date rec'd by registrar) Dec 20 1947 Amanda Downey, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 18, 1947 at 11:00AM.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 7 1947 to Dec 18 1947 and that I last saw him alive on Dec 18 1947

Immediate cause of death	DURATION
Cancer	
Hypertensive cardio-renal disease	
Due to Chronic nephritis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Uremia with Glomerulonephritis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George J. Hagerage M. D. or other
Address: 3717-38th St. Date signed: 12/18/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11516

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Prince George's

City or town Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 hrs

Hospital, institution, or street address where death occurred: Hyattsville Jail

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1122 Florida Ave

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME James Henry Moriarty

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Matilda Garrett Moriarty

6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) August 29, 1896

8. AGE: Years	Months	Days	If less than one day
51			hrs. min.

9. Birthplace Brownsville, Md (Town, county, and state)

10. Usual occupation mechanic

11. Industry or business Oil burners

FATHER 12. Name John Moriarty

FATHER 13. Birthplace Virginia

MOTHER 14. Maiden name Ada Thompson

MOTHER 15. Birthplace Maryland

16. Informant Matilda G. Moriarty

Address 1122 Florida Ave Washington DC

17. Burial (Burial, cremation, or removal—Which?) Date thereof Dec 14, 1947 (month) (day) (year)

Cemetery or crematory Evergreen

Location Bladensburg Md.

18. Funeral director F Gaschi Sons

Address Hyattsville Md.

19. Dec 13 1947 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1947 at 3 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary thrombosis	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE Deputy medical Examiner M. D. or other

Address Bowie Md. Date signed 12-12-47

11517

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:
County Prince Georges
City or town University Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3½ years
Hospital, institution, or street address where death occurred:
4417 Van Burens Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Georges
City or town University Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4417 - Van Burens Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Louis Harry Nesline

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Erika Nesline
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 9, 1885

8. AGE: Years 62 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual occupation Retired
11. Industry or business Restaurant

FATHER
12. Name George Nesline
13. Birthplace Baltimore, Md

MOTHER
14. Maiden name Annie Gemmert
15. Birthplace Baltimore Md

16. Informant Mrs. Erika Nesline
Address 4417 Van Burens St University Park
17. Removal Dec 22, 1947
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory Saffell Funeral Home
Location 475 - H St N.W Washington DC
18. Funeral director J Gesche Sons
Address Wyattsville Md.
19. Dec 22 1947 James Seery
(Date rec'd by registror) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1947 at 12 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnoney within 3 months of death)

Major findings of operatioos ..... Date of op. .....
Aotopsy results .....
PHYSICIAN: Please noderline the caose to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

Deputy Medical Examiner
23. SIGNATURE James J. Floyd M. D. or other
Address Forestville Md Date signed 12-22-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH INDELIBLE INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11518 245

131a

Reg. Dist. No. ~~220~~

1. PLACE OF DEATH:
County: Prince Geo. Co.
City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. Geo Co.
City or town: Greenbelt
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5-C. Parkway Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Robert Arthur Nye

3. (b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Cora M. Nye
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec-10-1879

8. AGE: Years	Months	Days	If less than one day
78			hrs. min.

9. Birthplace: Babcayeon Canada
(Town, county, and state)
10. Usual occupation: Retired Salesman
11. Industry or business

FATHER 12. Name: unknown
13. Birthplace: England

MOTHER 14. Maiden name: unknown
15. Birthplace: England

16. Informant: Cora M. Nye
Address: 5-C-Parkway Rd Greenbelt Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-26-47 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery Washington D.C.
Location: Old Church Yard
18. Funeral director: Rosedale Md.
Address:

19. Dec 26 1947 (Date rec'd by registrar) James Seney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-23- 1947, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1945 to December 23 1947 and that I last saw h alive on December 22, 1947

Immediate cause of death	DURATION
Congestive heart failure	3 months
Due to: Hypertensive cardio-renal disease	5 years
Due to:	
Other conditions: Recurrent hemorrhages from urinary bladder after prostate Rx	18 months

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hans Woodall M.D.
M. D. or other
Address: 30-B Bridge Rd, Greenbelt Md. Date signed: 12-23-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

11519

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Dead on arrival

Hospital, institution, or street address where death occurred:

Leland Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prs. Georges

City or town: Riverdale Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4631 Woodbury Rd

(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: William Richard Penn

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 3, 1919

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
28				

9. Birthplace: Accokeek Md (Town, county, and state)

10. Usual occupation: Farm hand

11. Industry or business:

FATHER — 12. Name: John Thomas Penn; 13. Birthplace: Md

MOTHER — 14. Maiden name: Nellie M. Pickeral; 15. Birthplace: Md

16. Informant: Mr Maurice Weeks

Address: Riverdale Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 31, 1947 (month) (day) (year)

Cemetery or ~~crematory~~: Cedar Hill

Location: Suitland Md

18. Funeral director: F. Gasch's sons

Address: Hyattsville Md.

19. Dec 30 1947 (Date rec'd by registrar) Ma. Jac. Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-29, 1947 at 12.10 A.M. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__

and that I last saw h ____ alive on ____ 19__

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to Compound fracture of both thighs	
Due to Fracture of tibia and fibula, both legs, lower abdomen and pelvis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of injury 12-28-47

Where did injury occur? College Park (City or town) Prince Georges (County) Md (State)

Injured at home, farm, industry, public place (where?) Route 1

Means of injury: Pedestrian struck Injury was ____

23. SIGNATURE: Deputy medical Examiner M. D. or other

Address: Hyattsville Md Date signed 12-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11520

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

CERTIFICATE OF DEATH

Reg. Diat. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Pr. Geo. County
City or town: Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 yrs
Hospital, Institution, or street address where death occurred: Prince Georges Hospital
How long in hospital or institution? 16 days 17 hrs 15 mins

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pr. Geo Co.
City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5600-43rd Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Irene Oline Petersen

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: Emil Petersen
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 4 - 1879

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68	7	6		

9. Birthplace: as Island Pa
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:

FATHER
12. Name: Michael McNamara
13. Birthplace: Pa

MOTHER
14. Maiden name: Annie Sweeney
15. Birthplace: Pa

16. Informant: Olga C. Petersen
Address: 5600-43rd Ave Hyattsville Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: 12-13-47 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery
Location: Wash D.C.

18. Funeral director: H.W.C. Lewis & Co
Address: Riverdale Md.

19. 12/11 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-10 1947 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1947, to Dec 10 1947
and that I last saw her alive on Dec. 1947

Immediate cause of death	DURATION
Congenital Imbecility	
Due to	
Due to	
Other conditions: Carcinoma of Tongue Cancer removed Stomach	

(Include pregnancy within 3 months of death)

Major findings of operations: Autopsy
Date of op. Dec. 6, 1947
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Albert Leo M.D.
M. D. or other
Address: Hyattsville Md Date signed 12-10-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

151a

11521

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Prince George's

City or town Capitol Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Capitol Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. 406 - 59th ave

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Kemp.

LILLIE MAE POTTS

3.(b) Social Security Number 579-48-8891

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Stonewall Jackson Potts

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1871

8. AGE:

Years	Months	Days	If less than one day
76	0	4	..... hrs. ..... min.

9. Birthplace Montgomery Co. Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Seamstress

FATHER 12. Name John A. Kemp

13. Birthplace Montgomery Co. Md.

MOTHER 14. Maiden name Laura Thompson

15. Birthplace Montgomery Co. Md.

16. Informant Edna M. Gaines Capitol

Address 406 59th. Ave. Hts. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 13, 1947 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location .....

18. Funeral director The S. H. Hines Co.

Address 2901 14th. St. N.W.

19. Dec 11 1947 (Date rec'd by registrar) Carrie Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 1947 at 6:00 A M

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from Sept. 45, to Dec 11, 1947

and that last saw h alive on Dec 10 1947

Immediate cause of death Chronic Valvular heart disease

DURATION: From 9 yrs 6 Months 6 11

Due to Pulmonary oedema interstitial nephritis

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. Sloan, M.D. M.D. or other

Address P.O. Seat Pleasant 19 Md. Date signed Dec 11, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11522

159

Reg. Dist. No. 239

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Prince George
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Prince George
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rt 1 Box 98
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Helen Louise Powell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Dec 27, 1947

8. AGE: Years | Months | Days 2 | If less than one day ... hrs. ... min.

9. Birthplace Warren Hosp. Laurel Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Robert A Powell
13. Birthplace Crolvale, W. Va.

MOTHER
14. Maiden name Arlene Reese
15. Birthplace Gladys, Va

16. Informant Robert A. Powell
Address Route 1. Box 98 Laurel Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Dec. 29 1947
(month) (day) (year)

Cemetery or crematory Ivy Hill
Location Laurel Md.

18. Funeral director McNutt Donaldson
Address Laurel Md.

19. Dec 29 1947 M. V. Beasheare
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29/47 19... at 7:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/27/47 19... to 12/29/47 19...
and that I last saw her alive on 12/29/47 19...

Immediate cause of death	DURATION
Pneumaturia	
7 Mos gestation	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. M. Warren M.D.
M. D. or other
Address Laurel Date signed 12/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

11523

CERTIFICATE OF DEATH

Reg. Diat. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age if especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Prince George.
City or town: Brentwood.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George.
City or town: Brentwood.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3904 - 38 Street.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lucy Marie Curnell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	White	married

6.(b) Name of husband or wife: Allan Curnell
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Aug 12 1882

8. AGE:

Years	Months	Days	If less than one day
65	3	16	..... hrs. ..... min.

9. Birthplace: Stephen City, Va. (Town, county, and state)
10. Usual occupation: Housewife.
11. Industry or business: Ho.

FATHER
12. Name: William Arndorff
13. Birthplace: Winchester, Va.

MOTHER
14. Maiden name: Sarah Johnson
15. Birthplace: Winchester, Va.

16. Informant: Allan Curnell
Address: 3904 - 38th St. Brentwood, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-14-47 (month) (day) (year)
Cemetery or crematory: Stephens City Cemetery
Location: Stephens City Va.

18. Funeral director: W W Chaney & Son
Address: Riverdale, Md.

19. Dec 12 1947 (Date rec'd by registrar) James Devon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 10 19 47 at 7 55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2 19 47 to Dec 10 19 47 and that I last saw h[illegible] alive on Nov 18 19 47

Immediate cause of death	DURATION
Acute Pulmonary Edema.	15 "
Due to Cardiovascular Hypertension	
Due to Senile	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Howard I Thorne M.D.
M. D. or other
Address: 28 Carroll Ave Takoma Park, Md. Date signed 12/16/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11524

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince George

City or town: Clinton Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George.

City or town: Clinton Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: Henry Jackson Rice

3.(b) Social Security Number:

4. Sex	5. Color or race	6. If single, married, widowed, or divorced
male	White	widower

6.(b) Name of husband or wife: Annie Atwell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 27, 1863

8. AGE:

Years	Months	Days	If less than one day
84	1	18	hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Produce Merchant

11. Industry or business:

FATHER

12. Name: William H Rice

13. Birthplace: Virginia

MOTHER

14. Maiden name: Maria Ann Barber

15. Birthplace: Virginia

16. Informant: Ethel Rudy (Daughter)

Address: Clinton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 19. 1947 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location:

18. Funeral director: James Lee Sons Co

Address: 3004 4th St N.E. D.C.

19. Dec. 16 1947 (Date rec'd by registrar) Edna F. Collins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 15th 1947, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 1945 to Dec 15 1947 and that I last saw him alive on Dec 15th 1947

Immediate cause of death: Cerebral Hemorrhag — DURATION: 8 hrs

Due to: Arteriosclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John E Bowers M.D. M. D. or other

Address: Brandywine Md Date signed: 12/15/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a 11525

Reg. Dist. No. 232

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Bowie Station
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Croome Station
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Charles C. Sasscer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

6.(b) Name of husband or wife: Ellen L. Thompson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 9 - 1867

8. AGE:

Years	Months	Days	If less than one day
80	9	15	hrs. min.

9. Birthplace: Mt. Key Park, Garrett Co., Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Henry B. Sasscer
13. Birthplace: Md
MOTHER 14. Maiden name: Mary M. Gibbons
15. Birthplace: Boyntown, Alleg. Co., Md.
16. Informant: Charles S. Sasscer
Address: 6207 Ritchie Rd., Wash. 19, D.C.
17. Burial (Burial, cremation, or removal? Which?) Date thereof: 12-27-47 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland, Md.
18. Funeral director: Ritchie Bros.
Address: Upper Marlboro, Md.
19. Dec 26 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 24 1947, at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 18 1947, to Dec 24 1947, and that I last saw him alive on Dec 24 1947.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	7 days
Due to: General Arterial Sclerosis	several years
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide? Cerebral Hem Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE: [illegible] M. D. or other
Address: Washington 19 DC Date signed: DEC 25 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 11526

Reg. Diat. No. 239

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Prince George
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 yrs
~~Hospital, Institution~~, or street address where death occurred:
515 Prince George St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Pr. George
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. 515 Prince George St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Eliza Jane Scatt

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife William N. Scatt
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 29, 1872

8. AGE:

Years	Months	Days	If less than one day
75	4	19	..... hrs. ..... min.

9. Birthplace Laurel, Pr. Geo., Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Home
FATHER 12. Name Barney Farragin
13. Birthplace Baltimore, Md.
MOTHER 14. Maiden name Sarah S. Denney
15. Birthplace Odenton Md.
16. Informant Mrs. Estelle Scatt
Address 515 Pr. Geo. St. Laurel Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 20 1947 (month) (day) (year)
Cemetery or crematory Ivy Hill Cemetery
Location Laurel, Maryland
16. Funeral director Ed. Wilk Donaldson
Address Laurel, Md.
19. Dec 19 1947 M. Brashears
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1947 at 5:01 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 10 1946, to December 15 1947 and that I last saw h.. alive on December 15 1947

	DURATION
Immediate cause of death Chronic myocarditis	1 year
Due to	
Due to	
Other conditions Hypertrophic arthritis	8 years

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert S McEnney M.D.
M.D. or other
Address 40 W Main St Laurel Md Date signed 12/19/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46g 11527

Reg. Dist. No. 230

1. PLACE OF DEATH:
County Prince George's
City or town Berwyn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, institution, or street address where death occurred:
9500 - 52nd Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. #1 - 61st Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Marian Linton Stanner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	MARRIED

6.(b) Name of husband or wife John THOMAS STANNER
6.(c) If alive, give age 82 years
7. Birth date of deceased (mo., day, yr.) 18 August 1887

8. AGE:

Years	Months	Days	If less than one day
60	3	23	— hrs. — min.

9. Birthplace Maryville, Mo. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name William F. Snodderly
13. Birthplace Unknown

MOTHER
14. Maiden name Clara Lee Eckley
15. Birthplace Unknown

18. Informant Frances Lee Henning
Address 9500 - 52nd Ave, Berwyn

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 15, 1947 (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery
Location Suitland Md

18. Funeral director E. Gaecha Sons
Address Hyattsville Md

19. 12/12/1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 December 1947 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 October 1947 to 11 Dec 1947 and that I last saw her alive on 11 December 1947

Immediate cause of death Congestive Heart Failure; Hypostatic Pulmon. Congestion — DURATION

Due to Carcinoma Pancreas — DURATION

Due to Carcinoma Bladder — DURATION

Other conditions Left Hemiplegia — DURATION

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Pancreas & Bladder Date of op. 11-3-47

Autopsy results Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. L. Etienne M. D. or other
Address Berwyn, Md Date signed 12-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Birth and Death 11528

MARYLAND STATE DEPARTMENT OF HEALTH 161c

CERTIFICATE OF ~~STILLBIRTH~~

Reg. Dist. No. 245

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County: Prince George

City or town: Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution: Leland Memorial Hospital

Length of mother's stay in County: 2 yrs
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State: Maryland

County: Prince George

City or town: Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3101 Taylor St.
(If RURAL give LOCATION)

3. Name of child: Baby boy Steuler

4. Date of birth: 12/25/1946 Hour: 8:06 A.M.

5. Sex: male 6. Twin or triplet: no

7. No. of weeks pregnancy: 36 wks.

FATHER OF CHILD

8. Full name: Henry Vernon Steuler

9. Color: white 10. Age at time of this birth: 30 yrs.

11. Usual occupation: Printer

MOTHER OF CHILD

12. Full maiden name: Janet Lee Weidman

13. Color: white 14. Age at time of this birth: 29 yrs.

15. Usual occupation: Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 2

(b) How many other children were born alive but are now dead? none (c) How many other children were *born* dead? none

17. Did child die before labor? no. During labor? no.

18. Pregnancy, complications of: no

19. Labor: (a) Complications of: no

(b) Induced? no.

20. (a) Was there an operation for delivery? no (Yes or No)

(b) State all operations, if any: —

(c) Did child die before operation? —

During operation? —

21. Cause of ~~stillbirth~~ death. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes: erythroblastosis

(b) Maternal causes: —

22. I certify to the birth of this child who was born ~~dead~~* alive on the date and hour above stated.

Signature: H. C. Schaffenburg, Jr., M.D.
(Specify if M. D., midwife, or other)

Address: 4408 Lawndale Rd., Riverdale, Md.

23. (a) Burial (Burial, cremation or removal) (b) Date thereof: Dec 27 1947 (month) (day) (year)

(c) Cemetery or ~~crematory~~: Ft. Lincoln

24. (a) Funeral director: J. Boeckeler & Son

(b) Address: Hyattsville Md.

25. (a) (Date rec'd by registrar) (b) (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.

Health Officer, per

V. S. A10

* See Instruction C on stub.

Child lived 7 hr 39 min. died at 3:45 pm.

LETTER from hosp., dr., app. changing birthday shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FHM No. G 114 FEB 4 - 1948 **CERTIFICATE OF DEATH**

1860

11529

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 mos.

Hospital, institution, or street address where death occurred:
Eugene Lee Sanitarium

How long in hospital or institution? 1½ hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4701 Somerset Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs Anna Bertha Thiles

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Robert Stephen Thiles deceased

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): ~~Sept~~ Mar. 25, 1886

8. AGE: Years: 61 — Months: 3 — Days: 7 — If less than one day: ..... hrs. ..... min.

9. Birthplace: Lithuania (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER
12. Name: Julius J. Noll
13. Birthplace: Germany

MOTHER
14. Maiden name: Josephine Ritmian
15. Birthplace: Lithuania

16. Informant: Mrs. G. Thomson
Address: 4701 Somerset Rd., Riverdale Md

17. Burial (Burial, cremation, or removal — Which?) Date thereof: Jan 3, 1948 (month) (day) (year)
Cemetery or crematory: Perkins Chapel
Location: Springfield Add
18. Funeral director: L. Rusch Lemp
Address: Hyattsville Md

19. Jan 3, 1948 (Date rec'd by registrar) Mrs. Jan Severe Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31, 1947 at 8.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 30, 1947 to Dec. 31, 1947 and that I last saw h.. alive on Dec. 31, 1947

	DURATION
Immediate cause of death: Cerebral hemorrhage.	17½ hrs.
Due to: Arteriosclerotic hypertension heart disease.	yrs. ?
Due to: ecchymosis	
Other conditions: Abrasion, + ecchymosis about the left orbit.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Coroner James Boyd notified

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? Hyattsville (City or town) Prince Georges (County) Md. (State)

Injured at home, farm, industry, public place (where?) Public place

Means of injury: fell Injured at work?

23. SIGNATURE: H. O. Ackerhalter, M.D.
M.D. or other

Address: 4404 Queensberry Rd. Riverdale Md. Date signed: Dec 31, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 169

11530

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:
County Prince George's
City or town Bowie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, Institution, or street address where death occurred:
Pennsylvania Railroad Tracks
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Bowie
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Thomas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 48 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Bowie, Md. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Railroad

FATHER
12. Name Stephen Thomas
13. Birthplace Maryland

MOTHER
14. Maiden name Emma Fleet
15. Birthplace Maryland

16. Informant Mary F. Henry
Address Bowie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 10 47 (month) (day) (year)
Cemetery or crematory Ascension
Location Bowie Pa. Inc Co
18. Funeral director Masters Edelen & Son
Address Bowie Md

19. Dec 9 19 47 (Date rec'd by registrar) Mrs J. W. Gridley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 19 47 at 9:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death Hemorrhage and shock — DURATION
Due to Crushed chest, fracture of h the skull
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 12/6/47
Where did Injury occur? Bowie (City or town) P. G. (County) Md. (State)
Injured at home, farm, industry, public place (where?) RR tracks
Means of Injury Sitting on track and struck by train Injured while at work
Dep. Med. Examiner
23. SIGNATURE James D. Boyd M.D. or other
Address Forestville, Md. Date signed 12/7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45.15M

11531

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

121

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George's
City or town: Cheverly (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred: Prince George's General
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Maryland
City or town: Brentwood (If outside city or town limits, write RURAL and give nearest town)
Street No. 3709 Quincy Street (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Joseph P. Van Overmeer
3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Ella M.
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Nov. 22, 1870

8. AGE: Years	Months	Days	If less than one day
77	1	1	... hrs. ... min.

9. Birthplace: Detroit, Michigan (Town, county, and state)
10. Usual occupation: retired
11. Industry or business
FATHER 12. Name: Unknown
13. Birthplace
MOTHER 14. Maiden name: Unknown
15. Birthplace
16. Informant: Mrs. J.F. Mowatt
Address: 3709 Quincy Street Brentwood, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 26, 1947 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Washington, D.C.
18. Funeral director: Wm. J. Nalley
Address: 3200 - R. I. Ave. Mt. Rainier, Md.
19. Dec 25 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23 1947 at 2 [illegible] A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/15 1947, to 12/23 1947 and that I last saw h im alive on 12/23 1947

Cause	DURATION
Immediate cause of death: [illegible] Hypostatic Pneumonia, Myocardial failure	12/21/47
Due to (1) [illegible]	12/15/47
Due to (2) Appendicitis - abscess?	12/15/47

Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy result: Perforated Appendix & abscess
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: George [illegible] M. D. or other
Address: [illegible] Date signed: 12/23/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11532

131a

Reg. Dist. No. 245

1. PLACE OF DEATH:

County Prince George's

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred:

420 Boyd Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 420 Boyd Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Phillips Wager

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1878

8. AGE: Years 69 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business U.S. Govt.

FATHER 12. Name James P. Wager

13. Birthplace Virginia

MOTHER 14. Maiden name Harriett Coons

15. Birthplace Virginia

16. Informant Mrs. Lucy Wager Burroughs

Address 902-9 Street S.E., Washington, D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Dec 17, 1947 (month) (day) (year)

Cemetery or crematory Charlottsville

Location Va

18. Funeral director F. Gasch's sons

Address Wyattsville Md.

19. 12/17 1947 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...

and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death Congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

Deputy medical examiner

23. SIGNATURE James F. Boyd M.D. or other

Address Forestville Md Date signed 12-17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

11533

Reg. Diat. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Prince Georges

City or town Glen Arden

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, Institution, or street address where death occurred: First and Lincoln Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Glen Arden

(If outside city or town limits, write RURAL and give nearest town)

Street No. First and Lincoln Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Catherine Washington

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife William Washington 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 80 Months Days If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mary Wheeler

Address Glen Arden, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-24 1947 (month) (day) (year)

Cemetery or crematory Woodmore

Location Woodmore Md.

18. Funeral director Henry S. Washington & Son

Address 467 K St. NW Wash. D.C.

19. Dec 21 1947 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1947 at 2 00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Acute congestion	
heart failure	
Due to Cardio vascular	
renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Deputy medical Examiner

M. D. or other

Address Upper Marlboro Md Date signed 12-21-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13 8

11534

CERTIFICATE OF DEATH

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Pro Georges County
City or town: Boulevard Heights Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pro Georges Co
City or town: Boulevard Heights Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4808 Ellis Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James Tobias Webster

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Lola Pearl Webster
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Jan 17, 1895

8. AGE: Years	Months	Days	If less than one day
52			hrs. min.

9. Birthplace: Washington D. C.
(Town, county, and state)
10. Usual occupation: Painter
11. Industry or business: own self

FATHER
12. Name: Daniel Webster
13. Birthplace: Washington D. C.

MOTHER
14. Maiden name: Rachael Tolbert
15. Birthplace: Washington D. C.

16. Informant: Lola Pearl Webster
Address: Boulevard Heights Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 3, 1947 (month) (day) (year)
Cemetery or crematory: St. Barnahas
Location: Oxen Hill Maryland
18. Funeral director: F. Gasch 's Sons
Address: Hyattsville Maryland.

19. 1/2 (Date rec'd by registrar) 19 48 Amanda Dorsey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 31, 1947 19 at 4:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 19 47 to Dec 31 19 47
and that I last saw h[illegible] alive on Dec 30 19 47

Immediate cause of death	DURATION
Tuberculosis	
Due to Pulmonary tuberculosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James T. Ford M. D. or other
Address: Anacostia Date signed 1-3-48

W

I

T

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1310

11535

Reg. Diat. No. 239

1. PLACE OF DEATH:

County Pr. George

City or town Laurel, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Warren's Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Pr George

City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)

Street No. 409 Prince George
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Clinton E. Welling

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife Ellen Smith Welling

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 28, 1867

8. AGE:

Years	Months	Days	If less than one day
80	6	20	..... hrs. ..... min.

9. Birthplace Cliftons Farm, Howard Co., Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Truman C. Welling
13. Birthplace Howard Co.

MOTHER
14. Maiden name Mary Elizabeth Brashears
15. Birthplace Howard Co.

16. Informant Truman C. Welling
Address Laurel, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 21, 1947 (month) (day) (year)

Cemetery or crematory St. Mark's Cem.

Location Highland, Howard Co. Md.

18. Funeral director De Witt Donaldson

Address Laurel, Maryland

19. Dec 20 47 M. Brashears
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 1947 at 11:15 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 16 1947 to December 18 1947 and that I last saw h... in alive on December 18 1947

	DURATION
Immediate cause of death Uremia	
due to Chronic Arteriosclerosis	3 d
Due to Arteriosclerosis, generalized	10-15 yrs
Due to Senility	
Other conditions Chronic Myocarditis	10-15 yrs
Hypostatic Pneumonia	3 d

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. Stephens M.D.
M. D. or other

Address Laurel Maryland Date signed 12/20/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

153

11536

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County Prince George's

City or town Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 49 days

Hospital, Institution, or street address where death occurred:

Prince George's General Hospital

How long in hospital or institution? 49 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Riverdale

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6315 - Rhode Island Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James J. White

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 22, 1890

8. AGE: Years	Months	Days	If less than one day
57 ~~58~~	6	23	..... hrs. ..... min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual occupation machinist

11. Industry or business Unemployed

FATHER 12. Name William White

13. Birthplace Pennsylvania

MOTHER 14. Maiden name Mary Fowley

15. Birthplace Pennsylvania

16. Informant Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/18/47 (month) (day) (year)

Cemetery or crematory St. James Cemetery

Location Waverly N.Y.

18. Funeral director Cherry Chase Funeral Home

Address 5103 - Wis ave. Washington D.C.

19. Dec 17 1947 James Berry

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1947 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h ..... alive on ..... 19.....

Immediate cause of death ..... DURATION

Post operative shock .....

Due to Plastic operation .....

on hip skin graft for a .....

Due to Chronic ulcer [2.0.9.4.8 alb] .....

Other conditions Spinal Anaesthesia .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Deputy Medical Examiner

James J. Boyd M. D. or Other

Address Forestville Md. Date signed 12-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11537

CERTIFICATE OF DEATH

Reg. Dist. No. 243.

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 25 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 3 months, 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 1212 - 5th St., N. W. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME ALMANUS WILLIAMS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): January 6, 1925

8. AGE:	Years	Months	Days	If less than one day
	22	10	28	...hrs. ...min.

9. Birthplace: Chester, South Carolina (Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business: –

FATHER
12. Name: Sylvester Williams
13. Birthplace: Chester, South Carolina

MOTHER
14. Maiden name: Dona Robinson
15. Birthplace: Chester, South Carolina

16. Informant: Deceased

Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Dec. 5, 1947 (month) (day) (year)

Cemetery or crematory:

Location: to Washington, D.C.

18. Funeral director: Henry S. Washington & Son

Address: 467 N St. N.W. Wash. D.C.

19. Dec. 5, 1947 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 4 1947, at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 18, 1947, to DEC. 4 1947 and that I last saw h... /M. alive on DEC. 4 1947

Immediate cause of death: PULMONARY TUBERCULOSIS — DURATION: 1 yr 9 mos

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other

Address: Glenn Dale Md. Date signed: 12/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Ink correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1310

11538

CERTIFICATE OF DEATH

Reg. Dist. No. 2-2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Prince George

City or town: (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 5360 Oxen Hill Rd.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): Lifetime

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 5360 Oxen Hill Rd.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Vernon Eugene Williams

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Divorced

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1890

8. AGE:

Years	Months	Days	If less than one day
57			hrs. min.

9. Birthplace: Oxen Hill Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: George Williams
13. Birthplace: Oxen Hill Maryland

MOTHER
14. Maiden name: Harriet Frazier
15. Birthplace: Maryland

16. Informant: Blanche Smith
Address: 5360 Oxen Hill Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 20, 1947 (month) (day) (year)

Cemetery or crematory: Oxon Hill, Maryland

Location: Oxon Hill, Maryland.

18. Funeral director: John T. Kluness & Co

Address: 901 Third Street S W

19. Dec. 18 1947 (Date rec'd by registrar) Edna F. Ellis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 1947 at 7.30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 1947 to December 16 1947 and that I last saw him alive on December 15 1947.

	DURATION
Immediate cause of death: Acute Cardiac Dilatation with Oedema	4 days
Due to: Cardio-Vascular-Renal Disease	9 months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Cf operations

Df autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Luther J. Scott M.D.
M. D. or other

Address: 2504 Nichols Ave S.E. Date signed 12-16-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1153

1860

CERTIFICATE OF DEATH

Reg. Diat. No. 245

1. PLACE OF DEATH:

County: Prince George's

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hours

Hospital, institution, or street address where death occurred: Leland Memorial Hospital

How long in hospital or institution? 3 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Vermont County: Rockingham

City or town: West Minster West

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Arthur Vyne Woodworth

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emma Hall Woodworth

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): August 21, 1872

8. AGE: Years 75 | Months — | Days — | If less than one day: hrs. min.

9. Birthplace: Iowa (Town, county, and state)

10. Usual occupation: Minister

11. Industry or business: Congregational Church

FATHER — 12. Name: William W. Woodworth

FATHER — 13. Birthplace: Connecticut

MOTHER — 14. Maiden name: Lydia A. Sessions

MOTHER — 15. Birthplace: Hampden, Mass.

16. Informant: Mrs. James M. Quinn

Address: 4309 Tuckerman St., University Park, Md.

17. Disposition: Transportation (Burial, cremation, or removal. Which?) Date thereof: Dec 25, 1947 (month) (day) (year)

Cemetery or crematory: Hillside Cemetery

Location: Cheshire Conn.

18. Funeral director: E. Gaeta Sons

Address: Hyattsville Md.

19. Dec 25 1947 (Date rec'd by registrar) Mrs. Jean Segers, Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 23 19 47, at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h ..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to: Fracture of base of skull	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 12-23-47

Where did injury occur? University Park (City or town) Prince George's (County) Md. (State)

Injured at home, farm, industry, public place (where): Home of daughter

Means of injury: Fell down cellar stairs Injured at work? No

Dept. medical Examiner

23. SIGNATURE: James H. Bond M. D. or other

Address: Forestville Md. Date signed: 12-24-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING